

Patient Last Name _____

First _____

Date of Birth _____

PAST MEDICAL HISTORY

Please check the box to indicate if you have a history of any of the following medical problems. Select all that apply.

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> AFIB | <input type="checkbox"/> Enlarged Prostate | <input type="checkbox"/> Pacemaker/Defibrillator | <input type="checkbox"/> I have no past medical problems |
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Epilepsy/Seizure Disorder | <input type="checkbox"/> PE/Pulmonary Embolism | |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Reflux Disease/GERD | |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease/Heart Attack | <input type="checkbox"/> Rheumatoid Arthritis | |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Rheumatologic Disorder | *Type of Cancer _____ |
| <input type="checkbox"/> Cancer(s)* | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Scoliosis | Are you currently being treated? |
| <input type="checkbox"/> Cardiac Stent | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Sickle Cell Anemia | <input type="checkbox"/> No |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Yes |
| <input type="checkbox"/> COPD/Emphysema | <input type="checkbox"/> Mental Health Issues | <input type="checkbox"/> Stroke/TIA | If yes, please describe treatment _____ |
| <input type="checkbox"/> Dementia/Alzheimer's | <input type="checkbox"/> MRSA Infection | <input type="checkbox"/> Thyroid Disease | _____ |
| <input type="checkbox"/> Developmental Delay | <input type="checkbox"/> Neuropathy | <input type="checkbox"/> Other: _____ | _____ |
| <input type="checkbox"/> Diabetes - Type I/II | <input type="checkbox"/> Osteoarthritis | | |
| <input type="checkbox"/> DVT | <input type="checkbox"/> Osteoporosis | | |

SURGICAL HISTORY

- No prior surgeries

List prior surgeries & dates if known:

Have you ever experienced anesthesia complications?

- No
- Yes, please explain below

FAMILY HISTORY

Please check the box to indicate if your **Mother and/or Father** have a history of any of the following medical conditions. Select all that apply.

- | | | |
|--|---|--|
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Malignant hyperthermia | <input type="checkbox"/> No Family History |
| <input type="checkbox"/> DVT/PE | <input type="checkbox"/> Rheumatologic disorder | <input type="checkbox"/> Unknown/Adopted |

SOCIAL HISTORY

Current Marital/Legal Status:

- Single
- Married
- Legally Separated
- Divorced
- Domestic Partner
- Widowed

LIVING ARRANGEMENTS

- Alone
- Caregiver for others
- Family/Roommate
- Dependent on caregiver for daily activities
- Retirement Community
- Skilled Nursing Facility
- Assisted Living

FALL HISTORY

Have you fallen in the past 12 months?

- Yes
- No

If yes, have you fallen more than one time?

- Yes
- No

PATIENT INFORMATION

Hand Dominance. Which hand do you write with? Right Left

Tobacco/Nicotine Use. Non-user Current user Former user. Year Quit _____

If a current or former user, check the type used:

- Cigarettes E-cigarettes Vape Cigar/pipe Smokeless Nicotine gels/dissolvable

Alcohol Use. Please indicate which best describes your habits

- Current Alcohol Use Occasional Alcohol Use Rare Alcohol Use Never Used Alcohol

Drug Use.

- No Illicit Drug Use Recreational Drug Use Type used, if applicable: _____

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MEDICATIONS List all current medications – including prescription, non-prescription, vitamins, and supplements.

I have reviewed my medications and there are no changes since my last appointment. Patient initials _____

Medication	Dose/How Taken/How Often	Medication	Dose/How Taken/How Often
1 _____	_____	6 _____	_____
2 _____	_____	7 _____	_____
3 _____	_____	8 _____	_____
4 _____	_____	9 _____	_____
5 _____	_____	10 _____	_____

ALLERGY & REACTIONS List all allergies including metal and latex.

Name of Allergy	Reaction	Name of Allergy	Reaction
1 _____	_____	3 _____	_____
2 _____	_____	4 _____	_____

LOCATION OF CURRENT PROBLEM / REASON FOR THE VISIT Please indicate by checking the most accurate reason

Upper Extremities

- Upper Arm/Shoulder/Clavicle
 Right Left Both
- Elbow/Forearm
 Right Left Both
- Wrist/Hand/Fingers
 Right Left Both

Lower Extremities

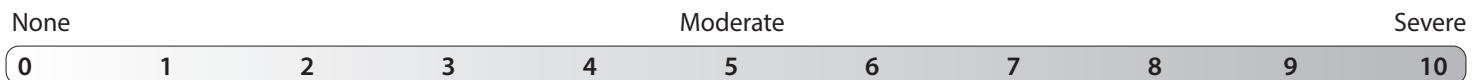
- Hip/Thigh
 Right Left Both
- Knee/Lower Leg
 Right Left Both
- Ankle/Foot/Toes
 Right Left Both

Spine

- Neck (Cervical)
- Middle (Thoracic)
- Lower (Lumbar)

Chief Complaint – Please select all that apply. Pain Tingling/Numbness Weakness Other: _____

Pain Severity – Without taking pain medication and while performing normal daily activities.



Approximately how long has this problem/concern been on going? _____

Is this associated with an injury? No Yes If yes, how were you injured? _____

Date of injury: _____ Is your injury work related? No Yes

If work related: BWC/Managed Care Organization: _____ Claim Number: _____

PREVIOUS TREATMENTS FOR THIS PROBLEM

- Acupuncture
- Bracing/Splinting
- Chiropractic Care
- Gel Injection
- Massage
- Medications/Supplements
- *Type of Surgery _____
- Therapy Physical/ Occupational/Hand
- Podiatry
- Steroid Injection
- Surgery*
- Other: _____

PREVIOUS TESTING FOR THIS PROBLEM

- CT (CAT) Date: _____ Location: _____
- EMG Date: _____ Location: _____
- MRI Date: _____ Location: _____
- X-Ray Date: _____ Location: _____
- Other Date: _____ Location: _____
- Other: _____
- No Previous Testing

CURRENT WORK STATUS

Which most accurately describes your current work status?

- Working: Full Time Part Time
- Not Currently Working: Disabled Retired Student Unemployed

Employer _____

Occupation _____

Are you able to perform your job duties?

- Yes, all regular duties
- Yes, only light duties
- No, unable to perform any duties
- No, unable & currently on disability